Developing an Integrated Urgent Care Service

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Confusing (and piecemeal?) system
Existing NHS111 Service

Patient

100%

Call-handler

22% of cases come via a clinician

Largely nurses and paramedics – small % of GPs

111 Clinician

22%

8.0% Information

9.2% Ambulance

6.7% A&E

37.2% ‘Contact’

11.3% ‘Speak to’

5.0% Dental/phar

3.1% Other

5.5% Homecare

14.0% Not triaged

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The Drivers for change:

Prompted by:

- Urgent & Emergency Care Review
- Five Year Forward View
- Patient Insight
- Phase 1 Pilots
- Commissioners
- NAO Report on GP OOH
The vision for a **functionally integrated** 24/7 Urgent Care Access, Advice and Treatment Service

“If I have an urgent need, I can phone a single number (111) and they will, if necessary, arrange for me to see or speak to a GP or other appropriate health professional – any hour of the day and any day of the week.”
The four elements of an Integrated Urgent and Emergency care offer

- Multi-Channel Entry (Access)
- Structured Initial Assessment (Advice & Referral)
- Multi-disciplinary Clinical Hub (Further Assessment/Advice/Treatment/Referral)
- Face to Face (Assessment, Advice, Treatment & Referral)
Integrated Urgent care - Opportunities

Patient calls 111

100%

111 Call-handler

How many more cases will come through clinical assessment?

Clinical hub

Patient calls 999

100%

999 Call-handler

What skill groups are required in the clinical hub? GP, mental health nurse, pharmacist, dental nurse?

And what difference will it make to these percentages?

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Key Enablers of Integration

Contractual
• Shared Metrics
• New payment model
• Urgent and Emergency Care Network Leadership
• Lead Commissioner/Provider?

Technology
• Shared platforms and interoperability
• Access to Records
• Electronic Referral and Booking

Workforce
• Joint Capacity Planning

Directory of Services + Mobile DoS

Clinical Governance
Not about NHS 111 as a provider
Thank you for listening ......

We need your involvement to ensure that we develop this new service and commissioning standards together.